tion, could be used to promote interdisciplinary learning, not just on day release courses but with the use of recognized training practices for the education of nurses, health visitors and social workers. In the field of continuing medical education all members of the primary care team should be encouraged to attend meetings. Certainly the study days held at the RCGP on such topics as diabetes and asthma have been enriched by the participation of team members other than general practitioners.

The system of primary care in the UK is undoubtedly effective but could be improved. It is effective because it is based on general practice. If primary care is to remain the foundation of the National Health Service and if this care is to be delivered through primary care teams, then surely securing effective teamwork should have a higher place on our agenda.

COLIN WAINE

Chairman of council, Royal College of General Practitioners

References

1. Royal College of General Practitioners. *Quality in general practice. Policy statement 2.* London: RCGP, 1985.
2. Royal College of General Practitioners. *The front line of the health service. Report from general practice 25.* London: RCGP, 1987.
3. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health. The government's programme for improving primary health care (Cm 249).* London: HMSO, 1987.
4. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Caring for people (Cm 849).* London: HMSO, 1989.
5. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.
6. Gilmore M, Bruce N, Hunt M. *The work of the nursing team in general practice.* London: Health Visitors Association, 1974.
7. Gregson BA, Cartlidge A, Bond J. *Interprofessional collaboration in primary health care organisations. Occasional paper 52.* London: Royal College of General Practitioners, 1991.
8. Royal College of General Practitioners. *Emerging structures.* London: RCGP, 1991.
9. Royal College of General Practitioners. *Planning primary care. Occasional paper 57.* London: RCGP, 1992.
10. Rubin IR, Plovnick MS, Fry RE. *Improving the co-ordination of care: a programme for health team development.* Harvard, MA: Balinger, 1975.
11. World Health Organization. *Learning together to work together for health. Report of a WHO study group on multiprofessional education of health personnel: the team approach. Technical report series no. 769.* Geneva, Switzerland: WHO, 1988.
12. Jones RVH. *Working together — learning together. Occasional paper 33.* London: Royal College of General Practitioners, 1986.
13. Royal College of General Practitioners. *Prevention and the primary care team.* London: RCGP, 1986.
14. Walker A. *Physiotherapy in primary care* [MPhil thesis]. Exeter: University of Exeter, 1991.
15. Griffiths R. *Community care: agenda for action. A report to the Secretary of State for Social Services.* London: HMSO, 1988.

Address for correspondence

Dr C Waine, 42 Etherley Lane, Bishop Auckland, County Durham DH14 7QZ.

Undergraduate medical education: the challenge of change

AMONG the list of aims at its inception 40 years ago, the fledgeling College of General Practitioners gave high priority to the promotion of a general practice contribution to undergraduate education.[1] This first found expression in the 1950s in the pioneering efforts of the Edinburgh general practice teaching unit under Dick Scott. David Morrell at St Thomas's Medical School in London and John Walker in Newcastle upon Tyne were both influenced by their Edinburgh experience and took up the challenge in England. In Manchester, Pat Byrne was laying the foundations of his general practice department. All these and other pioneers were College personalities whose efforts during the 1960s and 1970s achieved so much. Having been associated with these early initiatives, the Royal College of General Practitioners gave a high priority to vocational training, before turning to other important issues such as the quality assurance initiatives of the 1980s.

Now, it is appropriate once more to take stock of the undergraduate scene, and to consider how best to promote a much needed re-orchestration of medical education in order to equip future doctors for their tasks in the year 2000 and beyond. There is widespread agreement that present curricula are grossly overcrowded with factual information which soon becomes out of date and which inhibits students from developing into creative, critical thinkers and problem solvers. Factors which should govern change include not only reduction in factual information but also increased attention to such principles as active learning, integration of basic sciences and patient care, early clinical contact, and a proper balance between hospital and the community and between curative and preventive care.

These and other issues have been clearly set out by the General Medical Council[2] and in an influential report from the King's Fund.[3] Each reinforces the other, emphasizing the need in undergraduate medical education for critical thinking, good communication — especially between doctor and patient — and an holistic approach to the care of patients and their problems. Both reports recognize that a shift of teaching into the community is inevitable. A greater emphasis on teaching in general practice is implicit in the recommendations and raises important issues such as the resources necessary to create an appropriate environment for learning and provisions to ensure that high standards of clinical teaching are maintained.

Student perceptions of the teaching offered by general practitioners are uniformly good. They welcome the teacher's enthusiasm, often more readily communicated in the one to one relationship characteristic of this learning setting. The encouragement students receive is sometimes in marked contrast to the teaching by humiliation still encountered in some hospitals. Though the days are gone when some professors of the traditional disciplines of medicine, surgery and obstetrics ingenuously enquired of general practitioners 'What can you teach that I cannot?', there is still much ignorance among faculties about what goes on outside the hospital, and there remains some confusion between community medicine and medicine in the community. Nevertheless, general practice undergraduate teaching has now come of age. The assumption by the National Health Service of some of the financial responsibility for reimbursing practice based teaching under the new contract for general practitioners is but one recognition of this.

In a changing medical world, it is becoming more difficult

for hospital based clinicians to impart their skills to new generations of medical students. The wisdom of continuing to base the teaching of medicine in the most costly sector of the health service is increasingly questioned. Society's views on the roles and functions of medicine emphasize a shift from cure to care. How can the necessary teaching on team and teamwork implicit in this shift best be implemented? These and other issues are among the challenges of change which must be faced. Academic general practice has something of importance to say on all these issues and, given a fair chance, could participate much more fully in the medical school than it has been allowed to do in the past.

Universities and medical schools are reacting to the current adverse economy by quests for 'soft' money (money from approved sources other than the university); this is to be found not in teaching, but in research, and research of a biomedical rather than health service nature, because traditionally that is where the money lies. Such a materialistic orientation has also been reinforced by 'research selectivity' (a critical appraisal of research within the university system which largely determines the allocation of university funds), to which all universities in the United Kingdom have been subjected. This is to the disadvantage of academic general practice which has a track record which, though increasing in volume and quantity of research, is seen to be relatively weak in biomedical terms. It is to be hoped that this imbalance will be redressed by the latest university initiatives under academic audit, in which high quality teaching will be valued and, it is hoped, rewarded. Academic general practice excels in this field, and if it can be shown to be strong, bases may then be created for a more equal partnership in which general practice can begin to play its full role along with more traditional academic disciplines to meet the challenge of change.

In this issue of the *Journal* Stanley and Al-Shehri[4] report their experiences in providing a general practice based approach to undergraduate medical education in which medical students are given a measure of responsibility for their own learning. Such a move towards self directed learning is very much in the spirit of the latest General Medical Council guidelines[2] and provides a model for other teachers. This paper is likely to be of interest to all general practitioners who teach medical students. In the past there have been expressions of uncertainty on the part of tutors over what priorities to give different topics in the rich mix to be found in day to day general practice. The idea of treating the learner as a partner with a stake in the educational enterprise should have a wide appeal, with applications in the clinical teaching of most other disciplines.

J D E KNOX

Lately head of department of general practice, University of Dundee

References

1. General Practice Steering Committee: A college of general practitioners. Report. *Practitioner* 1953; **170:** Supplement.
2. General Medical Council. *Guidelines for undergraduate medical education.* London: GMC, 1991.
3. Towle A. *Critical thinking. The future of undergraduate medical education.* London: King's Fund Centre, 1992.
4. Stanley IM, Al-Shehri AM. What do medical students seek to learn from general practice? A study of personal learning objectives. *Br J Gen Pract* 1992; **42:** 512-516.

Address for correspondence

Professor J Knox, Braeriach, Duncrievie Road, Glenfarg, Perthshire PH2 9PA.